STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	006106	A. BUILDING _____ B. WING _____	09/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL INDIANAPOLIS	1700 W 10TH ST INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a State complaint. Complaint: IN00108708 Unsubstantiated, lack of sufficient evidence. Date of Survey: 09-25-12 Facility number: 006106 Surveyor: John Lee, R.N. Public Health Nurse Surveyor Kindred Hospital Indianapolis is in compliance with 410 IAC 15-1.5-10, Utilization review and discharge planning services, Hospital Licensure Rules. QA: claughlin 10/10/12	S 000		